resolved by the Department and the hospital or that require further information before resolution can be reached. Staff shall present the reports to the Committee at each quarterly AAC meeting.

b. Staff shall advise the AAC as to any cases that were not completed by the prescribed deadlines due to the volume of requests for Administrative Adjustment.

SECTION 4. FINAL DEPARTMENT DECISIONS ON ADMINISTRATIVE ADJUSTMENT CASES

A. Agreed-to Recommendations by Staff and Provider

1. Recommendations to which the staff and provider agree shall be forwarded directly to the Director of the Bureau of Health Care Financing (BHCF) for action without review by the Committee. Staff shall forward the case to the Bureau Director within seven days after agreement has been reached.

2. Within two weeks of referral, the Bureau Director shall either approve the recommendations or remand the case back to staff for further analysis.

3. The Director's decision to approve the recommendations shall be the final Department decision on the provider's request for an administrative adjustment.

4. Staff shall advise the provider if the Director remanded the case back to staff, and the procedures outlined in Section 2 shall be followed, as applicable.

5. A case that has been remanded back to staff by the Bureau Director for further analysis shall be considered by the AAC, whether or not the provider agrees with the revised staff analysis.
   a. If the provider agrees to the amended analysis, Department staff shall present the agreed-upon recommendations to the AAC. The provider representative need not attend the meeting but may do so if he or she so desires.
   b. At the AAC meeting, staff may not present or use financial and/or statistical information other than that already forwarded to and discussed with the provider representative.

B. AAC Recommendations

1. AAC recommendations on specific rate cases shall be submitted to the Director of the Bureau of Health Care Financing within one week of the AAC meeting. Based on available information, the Director shall act on the AAC cases within two weeks of receipt of them. Available information is defined as and shall be limited to the following items:
   a. Letter of request for administrative adjustment.
   b. Application package, including materials submitted by the provider in addition to that requested by the Department.
   c. Staff analysis and recommendations.
   d. Summary of disputed data and recommendations.
   e. A record of the AAC discussion of the case.

2. The Bureau Director shall either approve or disagree with the Committee recommendations.
   a. The Director's decision to approve the Committee's recommendations shall be the final Department decision on the case.
   b. If the Director disagrees with the Committee recommendations, the case shall be forwarded along with a summary of the disagreement to the Administrator of the Division of Health.

3. The Administrator of the Division of Health shall determine the outcome of the referred cases within three weeks of the referral. The Administrator's decision shall be based on available information, as defined above.

4. Staff shall advise the provider and the AAC as to the final decision on the case.

Next page is Page 62.
Page 61 has been removed with Attachment A for the outpatient case mix methodology included in the outpatient state plan and Attachment B for the adjustment for PEI/HMO going voluntary restated in §11900, item I, of this inpatient state plan.

29000 Policies for Medicare Exemption of Psychiatric Units

APPENDIX SECTION 29000
POLICIES FOR MEDICARE EXEMPTION OF PSYCHIATRIC UNITS

In order for a provider to qualify for placement in the "Medicare Exempt" peer group for Medicaid reimbursement purposes all of the following conditions and criteria must be met.

A. For Medicaid purposes, the provider does not discharge and readmit a patient when that patient is transferred from one acute care area of the hospital to another. Therefore, providers must maintain a separate unit log of all patients transferred into and out of the psych unit.

B. To be included in the "Medicare Exempt" peer group for Medicaid reimbursement purposes the provider must meet all the Medicare requirements, except those specifically identified as being exempted, for excluded units listed below and identified as follows:

1. General Criteria for Units.
2. Specific Criteria for Psychiatric Units.

The exceptions to the criteria listed in B.1 and 2 are as follows:

a. In all situations where the criteria refers to admission to the unit, the Department will use the term placement.
b. Items H and I under B.I will not be required for designation in the "Medicare Exempt" peer group for Medicaid reimbursement.

1. General Criteria for Units.

A. The unit must be a part of an institution that has in effect an agreement to participate as a hospital.
B. The unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.
C. The unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. (However, the medical records of unit patients need not be physically separate from the records of patients in the acute care part of the hospital, and it is not necessary to create a second medical record when a patient is moved from the acute care part of the hospital to the excluded unit, or vice versa. The record need only indicate, for Medicare purposes, the dates of the admission and discharge for patients of the unit.) The unit's policies must provide that necessary clinical information will be transferred to the unit when a patient of the hospital is admitted to the unit.

D. If State law provides special licensing requirements for psychiatric, rehabilitation, or alcohol/drug units, the unit must be licensed in accordance with the applicable requirements.
E. The hospital's utilization review plan must include separate standards for the type of care offered by the unit.
F. The beds assigned to the unit must be physically separate from (i.e., not commingled with) beds not included in the unit.

G. The unit and the hospital in which it is located must be serviced by the same fiscal intermediary.
H. The unit must be treated as a separate cost center for cost finding and apportionment purposes. (Not required for Medicaid.)
I. The accounting system of the hospital in which the unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation. (Not required for Medicaid.)
J. The cost report for the hospital must include the costs of the unit, must cover a single fiscal period and must reflect a single method of cost apportionment.

If a hospital wishes to have a unit excluded from prospective payment for a cost reporting period, it should notify its intermediary before the start of the period of the particular areas it has designated as the unit and of the square footage and number of beds in the unit. This notice should be sent to the intermediary at the same time notice is sent to the regional office regarding the request for exclusion (see §2803) and must identify the designated space through the use of room numbers and/or bed numbers. After the initial designation, changes in the amount of the space occupied by the unit or in the number of beds in the unit will be recognized for purposes of the exclusion only at the start of a cost reporting period.

2. Specific Criteria for Psychiatric Units

A. The unit must admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided only in an inpatient hospital setting, of a psychiatric principal diagnosis contained in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual, or in Chapter 5 ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

B. The unit must furnish, through the use of qualified personnel, psycho-logical services social work services, psychiatric nursing, occupational therapy and recreational therapy. Psychological, social work, occupational therapy, and recreational therapy services may be furnished either by hospital employees or under a contract or other arrangement with the hospital.

C. The unit must maintain medical records that permit determination of the degree and intensity of treatment provided to individuals who are furnished services in the unit, and that meet the following requirements.

1. Development of assessment/diagnostic data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.
   a. The identification data must include the inpatient's legal status.
   b. A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as psychiatric diagnoses.
   c. The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved or both.
   d. The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history;
   e. When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

2. Psychiatric Evaluation. Each inpatient must receive a psychiatric evaluation that must:
   a. Be completed within 60 hours of admission;
   b. Include a medical history.
   c. Contain a record of mental status;
   d. Note the onset of illness and the circumstances leading to admission;
   e. Describe attitudes and behavior;
   f. Estimate intellectual functioning, memory functioning, and orientation; and
   g. Include an inventory of the inpatient's assets in descriptive, not interpretive, fashion.

3. Treatment Plan.
   a. Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized, the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitative activities carried out; and
   b. The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.

4. Recording Progress. Progress notes must be recorded by the Doctor of Medicine or Osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient, but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.

5. Discharge Planning and Discharge Summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and

recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

D. The unit must meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as follows:

1. Personnel. The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:
   a. Evaluate inpatients;
   b. Formulate written individualized, comprehensive treatment plans;
   c. Provide active treatment measures; and
   d. Engage in discharge planning.

2. Director of inpatient psychiatric services: medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of Doctors of Medicine and Osteopathy must be adequate to provide essential psychiatric services.
   a. The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
   b. The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

3. Nursing services. The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.
   a. The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or is qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.
   b. The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.

4. Psychological services. The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with accepted standards of practice, service objectives, and established policies and procedures.

5. Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures.
   Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchanges of appropriate information with sources outside the hospital.

6. Therapeutic activities. The unit must provide a therapeutic activities program.
   a. The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
   b. The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.

End of Hospital Inpatient State Plan

X The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

APPENDIX I

MARKET BASKET CLASSIFICATION

MARKET BASKET CATEGORIES	PRICE INDICATORS	
	VARIABLE	SOURCE
(1) Professional Fees:		
(a) Physicians' Salaries, Wages Fees and Benefits	Physicians service component	Consumer Price Index, All Urban Consumers
(b) Other Professional Fees	Hourly earnings, production or non-supervisory. Private non-agricultural employees	U.S. Department of Labor
(c) Wages and Salaries	National average hourly earnings of hospital workers (SIC 806)	U.S. Department of Labor
(2) Employee Benefits	Supplements to wages and salaries per worker in nonagricultural establishment	U.S. Department of Commerce Bureau of Economic Analysis
(3) Food	Average of processed foods and feeds component of PPI, and food and beverages component of CPI	Producer Price Index Consumer Price Index, All Urban Consumers
(4) Drugs	Pharmaceuticals and ethicals component	Producer Price Index
(5) Other Costs:		
(a) Chemicals	Chemicals and allied products component	Producer Price Index
(b) Medical Instruments and Appliances	Special Industry machinery and equipment component	Producer Price Index
(c) Rubber and Plastics	Rubber and plastics component	Producer Price Index
(d) Travel	Transportation component	Consumer Price Index, All Urban Consumers
(e) Apparel and Textiles	Textile products and apparel component	Producer Price Index
(f) Business Services	Services component	Consumer Price Index, All Urban Consumers
(g) All Other	All items	Consumer Price Index, All Urban Consumers
(6) Fuel and Utilities (Indexed for interim purposes only; pass through on final settlement.)	All utility item	Consumer Price Index, All Urban Consumers

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APPENDIX II

TARGET FOR AVERAGE COMPENSATION PER EMPLOYE (ACPE)

I. Introduction

The hospital industry is one that is principally labor intensive, inasmuch as 60 percent or more of a hospital's operating expenses are comprised of salaries and employe benefits. Although there are some exogenous factors affecting the total compensation level, such as industry competition for available personnel and government-set FICA rates, the final total compensation level is set by hospital management. Since total compensation per employe is a variable within management's control, it is one that can be compared to measure hospital cost efficiency.

In order to ensure that the comparisons are meaningful, certain adjustments are necessary. These are: 1) bringing all hospitals to the same fiscal year end; 2) adjusting for geographical locations; and 3) placing hospitals in appropriate peer groups. Once these adjustments have been made, the 60th percentile of the peer group average is selected as the target for the average compensation per employe.

II. Methodology

The following steps will be used for deriving an average compensation per employe target for each hospital.

A. From the base year Medicaid Cost Report, take total hospital salaries plus fringe benefits and divide by total hospital full time equivalent employes (FTEs) to derive a base year average compensation per employe.

B. Adjust the Step A result to bring the subject hospital to the same fiscal year end as for all hospitals. The fiscal year end quarter to be used will be December 1981 (4th quarter).

C. Adjust the Step B result for the geographical location wage index for the subject hospital. (See Appendix IIA.)

D. Compare the Step C result by peer group components. The peer groups to be used for this target follow the WHRRP groups to the extent possible and are as follows:

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Group 1 (17 hospitals)

Frederic Municipal
Hazel Green Hospital
Iola Hospital
Osceola - Ladd Memorial
Viroqua - Vernon Memorial
Washburn - Bayfield County Memorial
Baldwin Community Memorial
Clintonville Community
Cumberland Memorial
Darlington - Lafayette County
Kewaunee - St. Marys
Lancaster Memorial
Oconto Memorial
Oconto Falls - Community Memorial
Shell Lake - Indianhead Memorial
Wautoma - Memorial Community
Wild Rose - Community Memorial

Group 2 (20 hospitals)

Algoma Memorial Hospital
Barron Community Memorial
Cuba City - Southwest Health Center
Durand - Chippewa Valley Area
Grantsburg - Burnett General
Hillsboro - St. Joseph's
Hudson Memorial
Mauston - Hess Memorial
Medford - Taylor County
Phelps - Northwoods
Plymouth Hospital
Stanley Victory Memorial
Arcadia - St Josephs
Bloomer Community Memorial
Boscobel Memorial
Hayward Area Memorial
Moncovi - Buffalo Memorial
Neillsville Memorial
Osseo Area Memorial
Spooner Community Memorial

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Group 3 (15 hospitals)

Amery - Apple River Valley
Black River Falls Memorial
Hartford Memorial
Ladysmith - Rusk County
Menomonie - Myrtle Werth
New Richmond - Holy Family
Park Falls - Flambeau Medical Center
Portage - Divine Savior
Prairie du Sac - Sauk Prairie
Richland Center - Richland Memorial
Sparta - St. Marys
Tomahawk - Sacred Heart
Watertown Memorial
Waupaca - Riverside Community Memorial
Whitehall - Tri-County Memorial

Group 4 (14 hospitals)

Dodgeville - Iowa County
Edgerton - Memorial Community
Kaukauna Community
Reedsburg Area Medical Center
Ripon Memorial
River Falls Area
St. Croix Falls - St. Croix Valley
Sturgeon Bay - Door County
Two Rivers Community
Eagle River Memorial
Friendship - Adams County
Milwaukee Foundation Hospital
Shawano Community
Tomah Memorial

Group 5 (13 hospitals)

Antigo - Langlade County
Baraboo - St. Clare
Chilton - Calumet Memorial
Columbus Community
Manitowoc Memorial
Merrill - Holy Cross
Milwaukee - St. Anthonys
New Berlin Community
New London Community
Rice Lake Community
Stoughton Hospital
Superior Hospital
Waupun Memorial

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Group 6 (12 hospitals)

Elkhorn - Lakeland
Green Bay St. Marys
Oconomowoc Memorial
Port Washington - St. Alphonsus
West Bend - St. Josephs
Ashland - Memorial Medical Center
Burlington Memorial
Chippewa Falls - St. Josephs
Fort Atkinson Memorial
Marinette General
Milwaukee - Northwest General
Wauwatosa - Lakeview

Group 7 (11 hospitals)

Beaver Dam Community
Berlin Memorial
Brookfield - Elmbrook Memorial
Manitowoc - Holy Family
Menomonee Falls - Community Memorial
Milwaukee - Family Hospital
Prairie du Chien Memorial
Rhinelander - St. Marys
Stevens Point - St. Michaels
Wisconsin Rapids - Riverview
Woodruff - Howard Young

Group 8 (15 hospitals)

Fond du Lac - St. Agnes
Janesville - Mercy Hospital
Kenosha - Memorial
Kenosha - St. Catherines
Monroe - St. Clare
Oshkosh - Mercy Medical
Sheboygan Memorial
Sheboygan - St. Nicholas
Appleton - St. Elizabeths
Beloit Memorial
Cudahy Trinity Memorial
La Crosse - St. Francis
Milwaukee - St. Francis
Racine - St. Marys
West Allis Memorial

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